POSITION TITLE: Project Coordinator/Case Manager.
PROGRAM: Primary Care
REPORTS TO: Director of Primary Care
LOCATION: Regional based in Anchorage

SUMMARY OF JOB RESPONSIBLITIES:
Work closely with management teams, grant writers, and clinical staff to develop and carry out programs that can improve the quality of life for our elders and seriously or chronically ill persons. "What can be done to make life as good as possible for as long as possible?" Identify needs and resources in our communities in regard to chronic illness, care of elders and palliative care. Coordinate the EAT Mental Health Trust Beneficiary Initiative; development of the palliative care project in conjunction with ANMC's "Helping Hands" project; and coordinate liaison relationship with ANMC's oncology department and other case managers. Participate in discharge planning conferences as needed to coordinate home care of seriously ill and elderly patients. Recruit, hire and train Community Care Coordinators (CCT) in appropriate communities. Participate in the gathering and distribution of educational/resource materials to communities using a variety of venues. Work closely with distance learning project to help develop and deliver necessary training/information. Assist with other projects as they relate to the care of chronically ill and their families.

OUTLINE OF ESSENTIAL JOB RESPONSIBILITIES/FUNCTIONS TO INCLUDE BUT NOT LIMITED TO:

- Coordinate the EAT Mental Health Trust Beneficiary Initiative
- Develop a dementia toolbox for caregivers/families, community members, and clinic staff with materials for quick reference for identification and reporting of Alzheimer's disease and related dementias.
- Supervise and support Community Care Technicians.
- Develop and deliver CCT training.
- Promote health care outcomes in concert with currently accepted clinical practice guidelines.
- Collaborate proactively with all interdisciplinary team members and with a patient-focus to facilitate and maximize client healthcare outcomes. Coordinates multi-disciplinary patient care conferences for high risk or medically complex patients as needed.
- Practice in accordance with applicable laws such as client confidentiality, Americans with Disabilities Act, Workers' Compensation, abuse reporting, principles of consent, and advanced medical directives.
- Case management services will be guided by ethical principles respecting the autonomy, dignity, privacy and the rights of the individual.
- Advocate for the client/family at the service-delivery level and at the policy-making level fostering the client's/family's decision-making, independence, and growth and development.
- Integrate factors related to quality, safety, efficiency, and cost effectiveness in planning, delivering, monitoring and evaluating client care promoting the most effective and efficient use of human and financial resources.
- Practice will be based valid research findings; specifically plans and interventions that result in high quality, cost-effective outcomes.
- Function as the liaison between clinic referrals and ANMC providers. Handles routine referrals in conjunction with EAT medical providers, schedules diagnostic studies, clinic

appointments and procedures, ensures travel/quarters are arranged. Coordinates with other service lines as needed.

- Utilize a tracking system for clients in the RPMS Fileman system to maintain an appropriate database of clients requiring follow-up (discharge, cancer, etc) and assures appropriate follow-up of clients.
- Develop, implement and coordinate the discharge plan for clients. Collaborates with other members of the health care team, the patient and family to develop and implement the plans. Provides teaching, arranges for travel, follow-up appointments, after care supplies and equipment for clients after discharge.

QUALIFICATIONS:

- Case management requires a professional credential, education, and experience.
- Graduation from an accredited school of nursing. Baccalaureate degree or higher level educational program in health and human services is preferred.
- Current registered nurse license in the State of Alaska.
- Experience in staff supervision.
- Basic Life Support (BLS) certification is required.
- Advanced Cardiac Life Support (ACLS) certification is preferred.
- Minimum of 6 years nursing experience with the health needs of the population served (Medical/Surgical) is preferred. Other work experience may be considered.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of health, social service, and funding sources.
- Ability to develop and implement training programs.
- Ability to supervise and train staff.
- Ability to utilize evidenced based practice to develop the plan of care and interventions.
- Ability to gather, and then critically and objectively evaluate relevant data to determine the need for intervention by a case manager.
- Ability to assess resource utilization and cost management of the treatment course and services.
- Ability to select a caseload reflecting practice patterns and trends in which client outcomes can be positively influenced.
- Ability to recognize patterns of care the may lead a client into a case management program.
- Ability to develop a case management plan that identifies immediate, short term and ongoing needs as well as where and how this care needs can be met.
- Ability to set goals and time frames for achievement of goals that are appropriate to the individual, his/her family, and agreed to by the client/family and treatment team.
- Ability to assess that funding and/or community resources are available to implement the plan.
- Ability to check, supervise and document the quality of care, services and products delivered to the client to determine if the goals of the care plan are being achieved, or if the goals remain appropriate and realistic.
- Knowledge of a methodology designed to measure the client's response to the healthcare services and products being delivered, while also measuring the effectiveness/necessity/efficacy of the care plan itself, and the quality of the services and products from the providers.

- Ability to identify and coordinate changes in practice patterns and treatment plans to bring about appropriate care and cost-effective outcomes.
- Ability to effectively teach processes and principles in planning, providing and evaluating optimum health care.
- Knowledge of scope of patient care services provided by other clinical service lines and the referral process.
- Knowledge of discharge planning practices and ability to coordinate multidisciplinary care.
- Knowledge of field health referral system and the ability to coordinate travel/quarters, appointments and procedures.
- Knowledge of clinic practices and ability to acts as resource for clinic personnel and assist the physician as necessary.

NATIVE PREFERENCE: Under P.L. 93-638, as amended, the company pursues a policy of Native preference in hiring, contracting, and training.

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Employee Signature Date

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Supervisor Signature Date